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AUTHOR Wood, Mary M.
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ABSTRACT

This final report discusses the outcomes of an outreach project based on the validated Developmental Therapy-Teaching model that emphasizes teaching skills which foster a child's social-emotional-behavioral competence. The project assisted early childhood and local child care programs in replicating components of the model in inclusive or pull-out settings for children (birth through 8) with social-emotional-behavioral disabilities and their families. Project evaluation data indicate that 731 participants at 13 program locations received inservice assistance in implementing the model in inclusive early childhood settings. Of these, 7 sites with 281 participants requested in-depth assistance to become replication sites. Post-training focus groups revealed that these participants acquired an expanded understanding of using a developmental framework for planning activities to meet individual needs of children. Their responses also indicated increased awareness of children's unique social-emotional-behavioral needs. In post-training observations of 65 participants working directly with children at 8 sites, 81 percent demonstrated "effective" or better performance skills. Data also show that a sample of 28 children at 3 sites made statistically significant improvement in social-emotional-behavioral development during a 6-month period while their teachers participated in inservice training. Summaries of the follow-up questionnaire and of focus group responses are attached. (Author/CR)

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ED 410 728

I. TITLE PAGE

SOCIAL COMPETENCE FOR YOUNG CHILDREN: AN OUTREACH PROJECT FOR INSERVICE TRAINING

(84.024D)

(Multi-State Outreach Project)

Final Performance Report
Oct. 1993-Oct. 1996
(Extended to Feb. 1997)
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Mary M. Wood, Interim Project Director
Developmental Therapy-Teaching Programs
P.O. Box 5153
Athens, GA 30601-2801
Phone: 706-369-5689
Fax: 706-369-5690
e-mail: mmwood@uga.cc.uga.edu

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1997

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II. EXECUTIVE SUMMARY

SOCIAL COMPETENCE FOR YOUNG CHILDREN: AN OUTREACH PROJECT FOR INSERVICE TRAINING
Final Report, 1993-96 (97)

Karen R. Davis, M.ME., R.M.T.
Project Director

Faye L. Swindle, Ed.D.
Training Associate

Mary M. Wood, Ed.D.
Senior Advisor

This outreach project is based on the validated Developmental Therapy-Teaching model originally designed for young children with severe emotional/behavioral problems and for their families. It is an approach that emphasizes teaching skills which foster a child's social-emotional-behavioral competence. The model has proven effective in inclusive settings with children who are socially, emotionally, or behaviorally delayed. It is also effective with children who have learning disabilities, autism, or language delays. Components of the model can be integrated into other early childhood preacademic curriculums, and include family involvement such as parental participation in assessment, program planning, and simultaneous home implementation of model practices as integral aspects of the model.

The project assists early childhood and local child care programs in replicating components of the model in inclusive or pull-out settings for children (from birth to age 8) with social-emotional-behavioral disabilities, including those with autism or developmental delay in social-emotional-behavioral development -- and their families. Recognizing that effective implementation depends upon the knowledge and skills of the adults who work directly with these young children, the project assists participants in understanding behaviors and acquiring specific skills to foster social-emotional-behavioral growth of these children. Emphasis is on model applications in typical daily activities such as social play, social language, listening and responding, creating, imagining, playing, and participating.

Specific project activities include: (1) *Dissemination of information* (2) *site development activities*, with outreach and inservice planning for introduction of the model as an addition to existing curriculum; (3) *model implementation* at selected replication sites, adapted to needs of participants and children at each site; and (4) *topical workshops* and general training at workshops and professional meetings for early childhood professionals, paraprofessionals, and families of young children in inclusive settings; (5) *regional & state agency collaboration* for program development and personnel training needs; and (6) *product development* to provide training materials for future inservice outreach via long distance learning, multi-media, and interactive materials.

Project evaluation data indicate that 731 participants at 13 program locations received inservice assistance in implementing the model in inclusive early childhood settings. Of these, 7 sites with 281 participants requested in-depth assistance to become replication sites. Post-training focus groups revealed that these participants acquired an expanded understanding of using a developmental framework for planning activities to meet individual needs of children. Their responses also indicated increased awareness of children's unique social-emotional-behavioral needs. In post-training observations of 65 participants working directly with children at 8 sites, 81% demonstrated "effective" or better performance skills. Data also show that a sample of 28 children at 3 sites made statistically significant improvement in social-emotional-behavioral development during a 6-month period while their teachers participated in inservice training.

The Developmental Therapy-Teaching Programs at the University of Georgia have a network in place to continue to disseminate products and to support programs or individuals seeking to replicate this model.

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IV. GOALS AND OBJECTIVES OF THE PROJECT

This inservice training project is designed to increase the capacity of professional and paraprofessional personnel and families to provide and enhance early intervention preschool programs with a social-emotional component for the young children they serve. Using the Developmental Therapy-Teaching curriculum model, a new adaptation of a previously validated intervention model, the project brings inservice opportunities to non-specialized personnel in inclusive early childhood service settings. Specific project goals are to:

1. Increase the understanding of personnel and families about how social-emotional competence develops and of practical ways they can promote development of prosocial behavior in young children.

2. Increase the skills of the participants in selecting and using developmentally appropriate strategies and activities to enhance children's social-emotional development.

3. Provide follow-up and support services to participants for skills maintenance in the early intervention environment.

4. Evaluate the project training model and disseminate results to programs and personnel, as requested, across the state and country.

V. CONCEPTUAL FRAMEWORK FOR THE PROJECT

The central issue for this inservice project is assisting participants in understanding the interactive dynamics of social, emotional, behavioral, and intellectual development of young children with disabilities so that developmentally appropriate experiences are provided in inclusive settings which foster social-emotional-behavioral growth. The

curriculum, a team-based model of comprehensive services, emphasizes strengthening the healthy process in every child which works to enhance social-emotional development and responsible behavior.

VI. DESCRIPTION OF THE TRAINING MODEL, ACTIVITIES, AND PARTICIPANTS

This inservice training model assists families and program personnel in using the validated Developmental Therapy-Teaching curriculum to help children derive pleasure and enrichment from normal childhood experiences. The training encompasses five distinct content areas: (1) recognizing and assessing normal milestones for healthy social-emotional development; (2) selecting developmentally appropriate activities and materials that enhance social-emotional development; (3) observing and decoding children's behavior for greater understanding of the actions through which they convey their social-emotional needs; (4) using growth-producing behavior management strategies to meet these needs; and (5) participating in team building activities which enhance program effectiveness.

The project was designed with a dual focus: **Component 1** addressed the inservice training needs of personnel and families working directly with young children; while **Component 2** addressed advanced inservice needs of leadership personnel with responsibility for the quality of the programs. While the essential content of the Developmental Therapy-Teaching curriculum model is necessary for each group of participants, the actual project activities differ in the delivery of inservice training. The first component utilized the following essential activities for personnel (primarily those who are non-specialized, in inclusive settings) and families providing direct service to young children:

- **Disseminate information** through circulation of materials, workshops, and presentations.
- **Assess local needs** with questionnaires, e-mail and Fax, correspondence, and telephone conferences.

- **Design inservice training agreements** including objectives, content sequences and support activities, workshops, and follow-up.
- **Implement inservice agreements and evaluate outcomes,** including participants' skills and progress of participating children when possible.
- **Adapt and redesign training materials** and media packages to meet expressed needs of participants in early childhood settings.
- **Develop new learning strategies** for the inservice training model as indicated by responses to process evaluation feedback from participants.
- **Provide inservice training credits** if requested by individuals.
- **Use evaluation results** to assess project effectiveness in accomplishing its purpose and goals of expanding and enhancing the skills of adults who influence the lives of young children with social-emotional-behavioral disabilities.

The second component utilized somewhat different activities to provide inservice training to preschool leadership personnel who have on-site, day-to-day responsibility to guide programs, support personnel and families, coordinate services, and ensure the quality of programs to young children. The project activities for these participants were highly dependent upon assessed needs of individuals to acquire comprehensive, in-depth knowledge and skills in assisting others to effectively implement the Developmental Therapy-Teaching curriculum. The following activities were used selectively to conduct this second component:

- **Determine individual participant's needs** in order to fulfil leadership responsibilities in including a high quality Developmental Therapy-Teaching curriculum among the program services to young children with disabilities and their families.
- **Collaboratively design and individualize inservice training sequence** specifying objectives, content, skills to be acquired, type of training and follow-up.
- **Implement intensive leadership training** through local, on-site tutorials, site-based follow-up focused on supervisory needs, and topical workshops teamed with project instructors in a collaborative tutorial design.
- **Guide leadership participants in developing a program evaluation plan** for the local site including training personnel in the reliable use of the evaluation instruments and

procedures, with effective classroom follow-up.

VII. METHODOLOGICAL AND LOGISTICAL PROBLEMS

There were several unanticipated factors which influenced this inservice project. The overall goal of the project was to increase the awareness and knowledge of primarily non-special education personnel concerning the social-emotional-behavioral growth of young children. This goal was achieved primarily in child care programs, including Head Start, therapeutic child development programs, and home child care programs. The difficulties encountered in accomplishing project goals actually provide a revealing look at the general state of services in the field and difficulties which programs face at the local level.

One of the primary problems in completing the workscope, as originally designed, was the vast turnover of personnel in the local programs. Recognizing that this occupation has one of the highest documented turnover rates, steps were taken to encourage staff stability within selected sites - for at least one calendar year and, hopefully, for more than one year. Before selecting sites several telephone conversations were held with administrators which highlighted the needs of the programs and the types of services to be offered through the project. For example, in the Central Valley of Washington, where four of the sites were located, a pre-training meeting was held with potential program participants. This meeting included the early childhood coordinator, teachers and paraprofessionals who were already involved in the use of the model (and providing demonstration assistance); Head Start teachers, team leaders and assistants; and Therapeutic Child Development program teachers, assistants, and administrators. A commitment was made by this project and local administrators to provide the training. Teachers were excited about the potential for training and follow-up. Yet, in two of the sites, pilot teams who were trained together were subsequently split by administrators and placed with other staff "because of their expertise." This skewed the pre-post data for the project. However, more important in terms of subjective factors was the negative effect on staff. Verbal feedback from those involved indicated lowered staff morale as a result of the changes. They felt a lack of input in decision-making and frustration that they were unable

to follow through in their new settings using strategies and classroom practices which they found exciting and effective. By the end of the third year, only one trained member remained on staff, and this person was at the assistant level, which gave her little opportunity for movement. These problems hampered the completion of the evaluation component even though the personnel actually involved with children completed initial training and had begun very effective classroom implementation as indicated by initial DT/RITS and DTORF-R data. Thus, high local staff turnover became a primary factor in documentation of project effects.

A second significant factor in the completion of the project was the need for local coordinators designated to directly communicate with the project staff. The responsibilities of these individuals included some oversight of child data and support and supervision of local staff. Much of the success of implementation relied on the abilities of this person to support the staff and to assist them in recognizing the importance of social-emotional-behavioral competence in the overall development of their youngsters. When this attitude was fostered by a local administrator and the collection of data was organized in a systematic manner, the teams flourished, and data indicated significant gains of children and positive attitudes of participants.

One proposed avenue of follow-up to local programs was not adequately tested within the parameters of the project. It had been proposed that video consultation/feedback would be available. The plan was that difficult classroom or child care situations would be videotaped and sent to the project office for review and conference call feedback. This strategy has been used effectively in other settings but was only used with one site in this project because of confidentiality limitations. The participating Therapeutic Child Development programs enrolled children who were court-placed. Guardians were the Department of Children and Family Services. It was the interpretation of the local worker in these programs that videos, even for educational purposes within the programs, were not permissible.

Perhaps the most rewarding measures of change are reflected in the individual comments of participants. These have been expressed through the focus group interview, workshop evaluations, and personal responses. Comments such as "This helped me to

understand children better than any other training" were common. Comments are included in the Attachments at the end of this report.

VIII. EVALUATION FINDINGS

The first evaluation question concerned general project outcomes. The question was the extent to which the project accomplished its mission, goals, and objectives, with activities as originally proposed. **Table 1** contains a summary of project outcomes and indicates that **all of the proposed project activities were implemented and accomplished or exceeded projected outcomes.** These findings, in brief, indicate that the project originally proposed to provide inservice outreach assistance to 10 - 15 sites and 503 service providers over the three-year grant period, thus expecting to impact programmatically on about 2,100 children. Actual results show that the project provided inservice activities at 13 different program locations with 88 on-site training days for 731 participants whose training impacted approximately 3,655 children with disabilities, (using an estimated average of 5 children per participating adult). Because the programs were inclusive by design, this figure does not include the larger, beneficial effect provided indirectly to many more young children without disabilities in these early childhood programs. In depth, extensive outreach was provided to 7 of the 13 locations which requested assistance in implementing the model adoption as a replication site. **Figure 1** outlines the essential requirements for model adoption met by these 7 sites.

Table 1. Project Outcomes: Summary Data

Outreach Activity	Projected	Accomplished
Information dissemination & awareness	4 states	**total = 10 States** Alabama Connecticut Georgia Kentucky Minnesota Nevada South Carolina Utah Virgin Islands Washington State
Information packages mailed		total = 179 information packages
DTORF-R assessment instruments mailed		total = 291 DTORF-R packages
Newsletters		total = 768 on mailing list
Presentations at conferences		total = 18 presentations to approx. 1,335 participants
Site development activities		
# Sites	10-15 locations	**total = 13 program locations***
# Participants	503 participants	**total = 88 training days**
# Children impacted	2100 children (est.@ 5 children per participant)	**total = 731 participants** **total = 3655 children impacted** (est. @ 5 children per participant)
Replication sites developed		**total = 7 replications sites**
site 1 - Learning Tree Therapeutic & regular child care Bremerton, WA		
Needs assessment	yes	yes
# Training visits		# training days = 8
# Participants	10	# participants, total = 38
# Children impacted	20	# children = 23 with disabilities
# Site visit reports	yes	# reports = 8
site 2 - Sunshine & Rainbows Therapeutic & regular child care Forks, WA		
Needs assessment	yes	yes
# Training visits		# training days = 4
# Participants	12	# participants, total = 50
# Children impacted	20-50	# children = 15 with disabilities
# Site visit reports	yes	# reports = 5

* The 13 sites receiving project services include the 7 programs identified as replication sites, plus 2 additional locations in the McIntosh Head Start program, 1 additional location in the EPIC Upper Valley Yakima program, 1 program in Athens, Georgia, 1 program as a "second generation" program under the leadership of a previously trained person, and 1 other site (Virgin Islands) which was well underway but destroyed in the '95 hurricane.

Table 1 (continued)

Outreach Activity	Projected	Accomplished
site 3 - EPIC - Upper Valley (2 locations) Castlevale Child Development Yakima, WA		
Needs assessment	yes	yes: # training days = 13
# Participants	12	# participants, total = 84
# Children impacted	20 - 50	# children = 12 with disabilities
# Site visit reports	yes	# reports = 16
site 4 - EPIC - Mid Valley Therapeutic Child Development Toppenish, WA		
Needs assessment	yes	yes; # training days = 14
# Participants	12	# participants, total = 53
# Children impacted	20	# children = 19 with disabilities
# Site visit reports	yes	# reports = 9
site 5 - EPIC - Lower Valley Therapeutic Child Development Sunnyside, WA		
Needs assessment	yes	yes; # training days = 10
# Participants	12	# participants, total = 26
# Children impacted	20 - 50	# children = 12 with disabilities
# Site visit reports	yes	# reports = 4
site 6 - McIntosh Head Start (3 locations) Spaulding, Pike, & Henry Counties, GA		
Needs assessment	yes	yes; # training days = 8
# Participants	12	# participants, total = 22
# Children impacted	30	# children = 30 with disabilities
# Site visit reports	yes	# reports = 7
site 7 - Monarch Child Care Lacey, WA		
Needs assessment	yes	yes; # training days = 4
# Participants	19	# participants, total = 8
# Children impacted	20	# children = 20 with disabilities
# Site visit reports	yes	# reports = 2
Topical workshops (Special 1 - day workshops on requested topics to groups other than potential replications sites)	50 participants	**Total = 13 topical workshops** **Total = 480 participants**

Table 1 (continued)

Outreach Activity	Projected	Accomplished
Regional/state agency collaboration	5 agencies	**total = 9 agencies** Connecticut Early Childhood Network Georgia State Agency Planning & Coordination Committee Gwinnett Coordinating Agencies NEC * TAS RAP, Chapel Hill, NC Virgin Islands Dept. Of Education Washington Educational Service Districts 113 & 114 Washington State DSHS Washington EPIC Mid-Valley area
Product development		
Slide/tape for assessment	yes	yes, final version field-testing
Video training segments	yes	yes, final version field-testing
• developmentally appropriate strategies for positive management of difficult behavior		
• developmentally strategic activities booklets		collection underway

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Figure 1

Essential Standards Met by 7 Sites Replicating the Model

Several minimal standards have been designated as necessary for a quality replication:

1. Initial staff training in the Developmental Therapy-Teaching curriculum.
2. Use of the Developmental Teaching Objectives Rating Form (DTORF-R) with an accuracy score of 75% correct or better.
3. Selection of services for children based on IFSP and IEP goals, and utilization of the model according to each child's developmental stage.
4. Use of the specified classroom practices and procedures as indicated by a classroom performance of 75% or better on the Developmental Therapy Rating Inventory of Teacher Skills (DT/RITS).
5. Involvement of the family and child's teachers in the DTORF-R ratings and evaluation of the Developmental Therapy-Teaching program when possible.
6. Provision for concomitant enrollment of each child in inclusive or integrated educational placement, when possible.
7. An evaluation plan which includes the use of the DTORF-R and the DT/RITS, reporting data on a pre-post basis along with other evaluation data required for annual reports. In addition, sites submit child progress data from at least one standardized instrument, when possible.

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The Evaluation Plan included efforts to determine the extent to which participants gained new knowledge and actually implemented this knowledge with increased skill in the service settings. Project evaluation was concerned also with the impact on the children taught by participants. Because systematic evaluation of staff and children at service centers is frequently limited by local policies, project effectiveness was evaluated using several different subject-selection procedures: self-selecting volunteers for focus groups and written follow-up questionnaires, randomly chosen children from sites where reliable child progress data were available, and teacher performance measures where permitted by local administrators. To judge project effectiveness with these selected subjects, the following evaluation questions were addressed and findings reported below:

Concerning the Participants Receiving Outreach Inservice Training:

After the training, do participants demonstrate understanding of the social-emotional-behavioral development of young children, the program needs they have, and the skills needed by adults to provide what is needed?

Two measures were used for gathering data to answer this question: a 32 item multiple-choice quiz administered directly before and after training, and an on-site focus group of volunteer participants discussing seven questions related to the effect of the training on their understanding of the model and its content regarding the social-emotional-behavioral development of children and their program needs.

The 32-item paper and pencil test was administered to 155 participants from 13 sites at the completion of their training. This multiple-choice test included basic knowledge of milestones for social-emotional-behavioral development, birth to age 5. As a group, the participants achieved an average of 22 items correct (70%). There was also a subset of both pre- and post-training data for 110 of these participants from 11 sites. They achieved an average of 20 items correct on the pre-test (range = 4 to 27) and 22 items correct on the post-test (range = 10 - 29) - a 12.4% improvement. These findings suggest that the test content may have included generally basic information about development that most early childhood educators should know prior to inservice training for this model. However, project instructors also noted that many participants had expressed discomfort over having to

"take a test" and many indicated confusion over words on the test. This suggested that a paper and pencil test might be an inappropriate means for measuring practical knowledge gained by these participants during the training.

To further explore this idea, the data were sorted into 3 groups. Group 1 participants had completed no more than a high school education or less (n = 19), Group 2 participants had some education beyond high school (n = 77) and Group 3 participants did not identify their educational level (n = 14). **Table 2** summarizes the performance of these three groups on the paper-pencil test.

Table 2. Knowledge Test Scores, Pre- and Post-Training

	N	Average Pre-Test Correct	(Range)	Average Post-Test Correct	(Range)	Improvement
Group 1	19	17	(9 - 25)	19	(10 - 26)	9%
Group 2	77	20	(4 - 27)	23	(10 - 29)	13.5%
Group 3	14	14	(13 - 25)	15	(11 - 28)	10%
Total	**110**	**20**	**(9 - 27)**	**22**	**(10 - 29)**	**12.4%**

It is clear that participants with more educational preparation (Group 2) were able to handle this written test more successfully than participants with less education. It may be that the test covered basic child development content so that those who had some prior course work were at a distinct advantage on both pre- and post-training testing. However, the data also brings into question the general validity of this form of evaluation. It leaves unanswered the question concerning the extent to which these participants' knowledge (as measured by paper and pencil test) increased during the training.

The focus group format seems to be a more suitable and effective way to assess participants' understanding. **Attachment A** summarizes the focus group responses for sites 1 and 2. These responses were recorded using audio tapes, as video appeared too intrusive for relaxed participation. Responses to each question were then summarized,

categorized, and ranked with most frequently repeated ideas reported first. The preliminary discussion in response to question 1 indicates that participants received varying amounts of training -- between 18 and 20 hours in total (negotiated individually with each site at the time of the needs assessment prior to training). Some of the participants had also received information about the model from a college class taught by leadership participant in the project.

All of the responses were positive about the content but conveyed concern about time constraints limiting the amount of effort that they can expend to implement exemplary practices. In spite of this concern, the responses to question 4 suggest that participants believed they had an expanded understanding of using a developmental framework for planning program activities to meet individual social-emotional needs and to guide each child's progress in a sequential, targeted direction. Responses to questions 2 and 3 indicate that participants had acquired understanding of the need to assess each child's social-emotional-behavioral development as the first step in establishing individual program objectives. Their responses also indicated they had increased awareness of the unique social-emotional needs of individual children and had acquired many of the recommended strategies to meet these needs. The conclusion to be drawn from these focus group discussions is that if time permitted, they would like to complete similar assessments for all of the children at the service settings, not just for those with disabilities.

After participation in the training, do participants demonstrate effective performance skills, which facilitate prosocial behaviors and social competence in the children they teach?

The *Developmental Therapy Rating Inventory of Teaching Skills* - Preschool Form (DT/RITS, Stage Two) was used by project instructors to observe and rate participants as they were observed working directly with children in the service setting. The instrument is designed to record the extent to which the suggested practices are being implemented. **Table 3** contains post-training ratings of 64 participants at 8 sites. These results indicate that 84% of the participants (53) achieved an "effective" or better performance rating. The highest, "demonstration", level was achieved by 8% and the "effective" level, by 75%. As

a group, the 64 participants demonstrated proficiency skills of .80. The previously established criterion standard of .71 or better for an "effective" rating, indicated that **the participants were able to demonstrate effective performance skills which had been specified in the inservice training to facilitate prosocial behavior and social competence.**

Table 3. Post-Training Performance Ratings of 64 Participants at 8 Locations

Site	n	Average Rating	Number of DT/RITS Ratings in Each Performance Category: Demonstration Level ≥.95	Effective Level .71 - .94	Passing Level .51 - .70	Below Passing Level ≤.50
1	8	(82.1)		8		
2	4	(76.0)		3	1	
3	15	(81.5)	3	8	3	1
4	9	(86.2)	1	8		
5	2	(77.0)		2		
6	11	(76.9)	1	6	3	1
7	5	(84.0)		5		
Other	10	(73.6)	8	2		
Total	**64**	**79.9**	**5**	**48**	**9**	**2**

Concerning Children with Disabilities at the Service Settings Where the Training Occurred: ***Do the children show significant progress in social-emotional-behavioral development, following the inservice staff training?***

The Developmental Teaching Observation Rating Form-Revised (DTORF-R) is the instrument used to measure a child's progress during the training period. DTORF-R training is among the first workshops provided to all sites for reliable use of this instrument.

DTORF-R profiles provide individual teaching objectives for each child's social-emotional-behavioral development. At the conclusion of the school year, or at scheduled times throughout a school year, children are reassessed on the same instrument and scores converted to developmental age scores (in months) for statistical analysis of the gains from pre- to post-program.

The staff at sites 1, 4, and 7 were able to complete both pre- and post- DTORF-R for children with disabilities in their inclusive programs, providing complete and reliable data for a total of 28 children. At the time of the first DTORF-R rating 28 children were 43.1 months old (range = 28 - 62 months) as a group, a little over 3.5 years old. Their developmental age at that time was 34.9 months - a developmental lag of 8.2 months. When the second DTORF-R assessments were made, their teachers had participated in the project for 5.5 months, on average, thus the group was then 48.6 months old. The average post-training DTORF-R rating for the group was 47.1, a 32.5% gain and only a developmental lag of 1.5 months. This encouraging evidence was further supported by statistical comparison of the pre-and post-scores using a dependent *t* test resulting in a statistically significant gain (t - 6.89; $p < .0001$). **These data clearly indicated that the children made dramatic gains reducing their lags in social, emotional, and behavioral development during the time of the staff inservice training.**

To explore the question of possible differences at different sites, each set of DTORF-R scores was also examined separately. **Table 4** contains DTORF-R data for 6 children at site 1. As a group, these children were 50 months old at the time of the pre-rating (4 years 2 months) with an average developmental age score of 44 months (3 years 8 months) representing an average 6-month lag in social-emotional development. At the time of the post-rating, the children were 56 months old as a group and had achieved an average developmental age score of 54 months, a gain of 10 months (a 23% improvement during the intervention period of 5.6 months on average), thus narrowing their developmental lag to 2 months.

Table 4.
CHILD PROGRESS DATA
Site #1
n = 6

ID #	Site #	Birthdate	DTORF-R Pre-DA (in months)	DTORF-R Post-DA (in months)	CA Pre/Mos	Time to Post	CA Post/Mos
05	1	02/04/92	44	54	47	4.5	52
06	1	12/16/92	33	48	44	4	49
07	1	09/30/91	54	59	59	4	63
08	1	01/13/94	40	48	29	7	36
09	1	11/23/90	50	62	62	7	69
10	1	01/30/91	41	51	59	7	66
Group Average			44	54	50	5.6	56
Average 3 Groups Combined			34.82	47.07	43.07	5.5	56
Group Average			35.2		48.57		

Table 5 contains the summary DTORF-R data for 17 children at site 4. As a group, these children were 42.8 months old at the time of the pre-rating (3.6 years old) with an average developmental age score of 32.7 months representing an average 10.1 months lag in social-emotional-behavioral development. At the time of the post-rating, the children were 48.0 months old as a group and had achieved an average developmental age score of 47.1 months, a gain of 14.4 months (a 43.9% improvement during the intervention period of 5.1 months) thus narrowing their developmental lag to .9 of one month.

Table 5.
CHILD PROGRESS DATA
Site #4
n = 17

ID #	Site #	Birthdate	DTORF-R Pre-DA (in months)	DTORF-R Post-DA (in months)	CA Pre/Mos	Time to Post	CA Post/Mos
11	4	05/02/92	43	47	42	6	48
12	4	12/13/93	23	33	33	5	38
13	4	05/02/92	43	44	42	6	48
14	4	03/04/92	24	39	47	4	51
15	4	06/15/93	23	40	33	10.5	44
16	4	09/03/93	18	33	39	2	41
17	4	11/05/93	21	35	35	4	39
18	4	09/30/93	9	35	31	9	40
19	4	12/17/91	41	57	58	6	64
20	4	03/31/92	66	74	55	6	61
21	4	12/25/92	15	46	36	3	39
22	4	12/25/92	40	43	40	5	45
23	4	02/24/93	43	61	43	6	49
24	4	10/07/91	24	37	55	5	60
25	4	09/12/92	40	47	41	3	44
26	4	09/03/91	50	62	53	3	56
27	4	03/31/92	33	67	46	3	49
Group Average			32.71	47.06	42.88	5.09	48.00

Table 6 contains DTORF-R data for 5 children at site 7, a much smaller program and slightly younger children. Post- ratings were completed 6.8 months following their pre-

DTORF-R rating. As a group, these children were 35.4 months old at the time of the pre-rating (2.95 years old) with an average developmental age score of 31.4 months representing a lag of 4 months in social-emotional-behavioral development. At the time of the post-rating, the children were 42.2 months old as a group and had achieved an average developmental age score of 39.2 months, a gain of 7.8 months during the intervention period (a 24.8% improvement during the intervention period) thus narrowing their developmental lag to 3 months.

Table 6.
CHILD PROGRESS DATA
Site #7
n = 5

ID #	Site #	Birthdate	DTORF-R Pre-DA (in months)	DTORF-R Post-DA (in months)	CA Pre/Mos	Time to Post	CA Post/Mos
28	7	03/26/93	14	29	34	6	40
29	7	01/05/93	35	50	37	11	48
30	7	01/15/93	67	52	45	4	49
31	7	10/10/93	12	22	28	8	36
32	7	11/20/93	29	43	33	5	38
Group Average			31.4	39.2	35.4	6.8	42.2

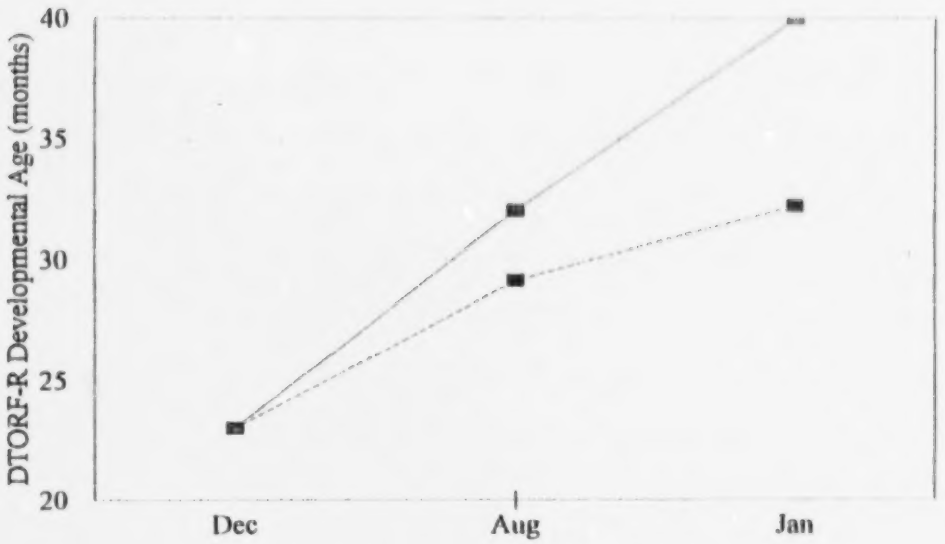
Although the developmental gains at each site varied slightly, these data support the conclusion that the project effect was positive across the sites with each group of children making notable gains and decreasing their developmental lags.

Repeated DTORF-R measures on 5 children allowed us to examine the question of their rate of progress before intervention as compared with rate of progress during intervention. Their individual progress graphs are reported in **Figures 2a - 2e.** Each child was measured at approximately the same time intervals -- approximately 3 to 4.5 months between each rating. The solid line indicates changes in developmental age at the measurement points. Four of the five children made gains at each measurement point.

Child #02 at Site 4 made distinct progress during the intervention, but this rate of progress was not as rapid as the projected rate. Program staff explained that the child was removed from home during this period. A traumatic reaction occurred with distinct regression in behavior. The dotted line indicates a hypothetical growth projection, serving as a control to determine if the gains were a function of program intervention or natural development. To obtain this projection, a rate of development prior to intervention was calculated using the DTORF-R developmental age score (in months) at the time of the pre- measure divided by the child's chronological age (in months). This prior rate of development was then used to project an individual rate of development during the intervention time period assuming no intervention had been provided and the child continued to progress at the prior rate.

Figure 2a. Individual Child Progress

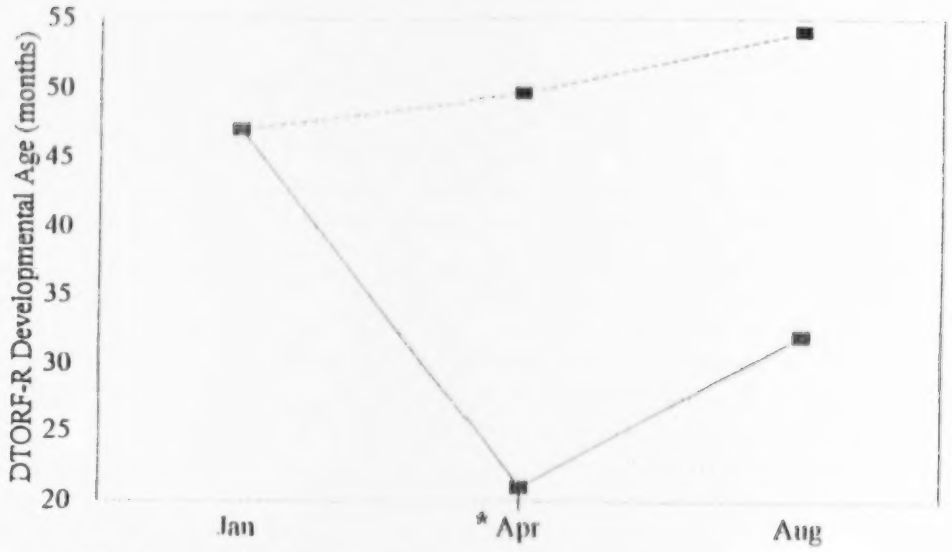
Site 1. Child #1



Solid lines = Actual rate of mastery during intervention
Dotted lines = Calculated rate of mastery assuming no intervention

Figure 2b. Individual Child Progress

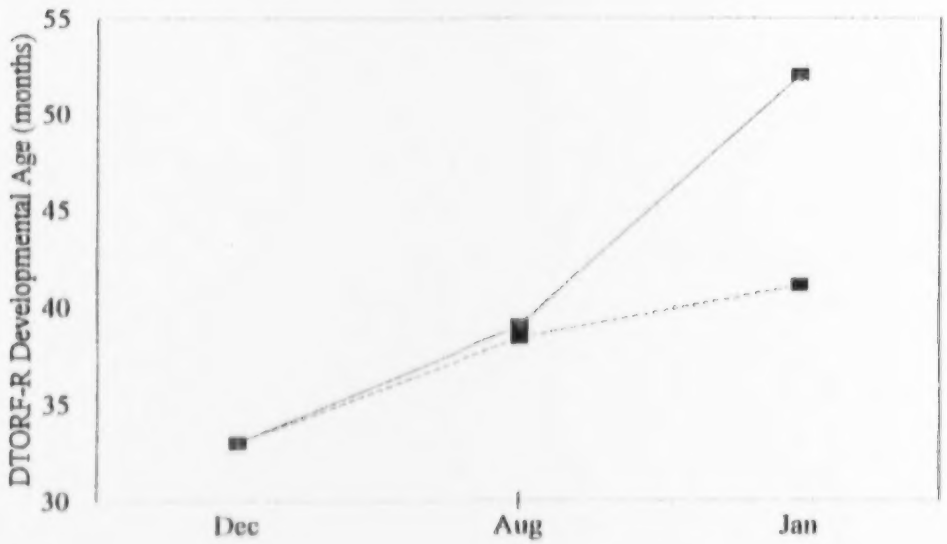
Site 1. Child #2



*Child removed from home

Figure 2c. Individual Child Progress

Site 1. Child #3



Solid lines = Actual rate of mastery during intervention
Dotted lines = Calculated rate of mastery assuming no intervention

Figure 2d. Individual Child Progress

Site 1. Child #4

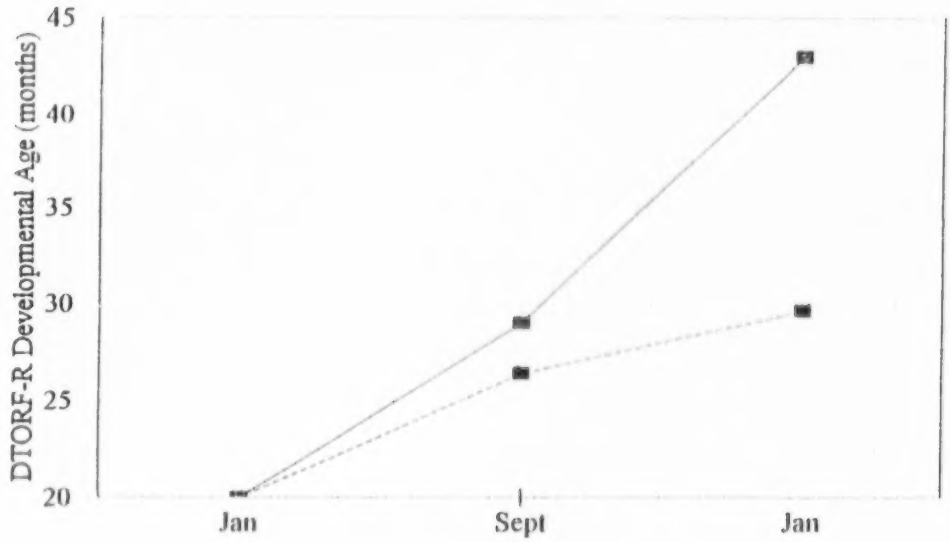
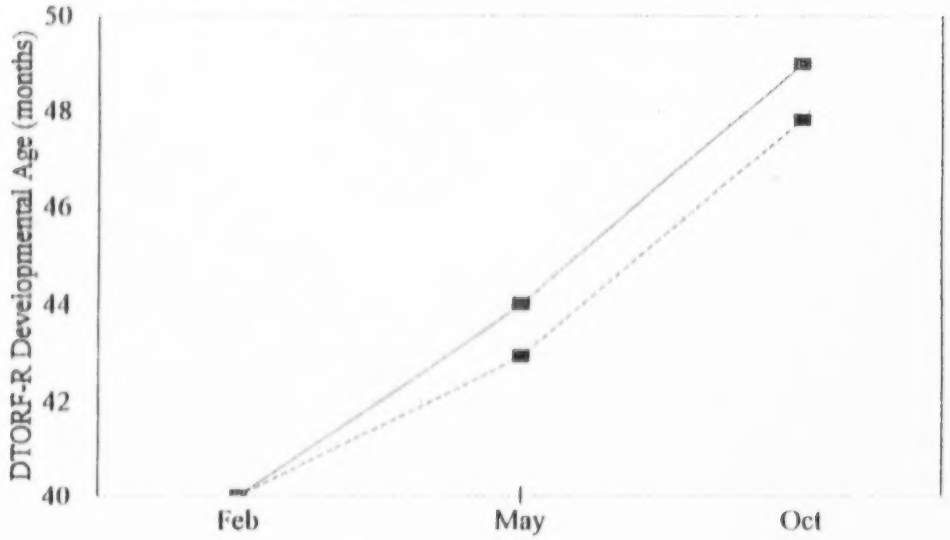


Figure 2e. Individual Child Progress

Site 4. Child #25



Solid lines = Actual rate of mastery during intervention
Dotted lines = Calculated rate of mastery assuming no intervention

These figures suggest that children at the sites receiving inservice training made significantly greater progress during that time period than might be expected without the intervention. The findings also indicate that the gains were maintained four to five months after training ends.

In summary, these analyses show that the effect of the project on the progress of children with disabilities is highly beneficial in terms of social-emotional-behavioral development.

Concerning the Project as an Effective Outreach Model for Inservice Training

Table 7 summarizes evaluations from 24 workshops including both special, topical sessions and those provided to developing replication sites as an aspect of the outreach technical assistance provided to them. Using a 5-point rating scale, with 5 being the best possible rating, 455 participants rated the quality of the materials presented as "very beneficial" (4.63), the workshop organization as "well organized" (4.63), and the overall impression of the workshop (4.71) as "excellent". They also reported that the workshops met their needs (4.46). The personal comments these participants added to the workshop evaluations are included as attachments. They provide a rich commentary as the positive effects of the workshops on participants.

Table 7
Cumulative Workshop Evaluations

Number of respondents = 455 Number of workshops = 24

Average responses for numeric ratings:		Rating scale = 5 - 1
		5 1
The material presented has been:	4.63	(Very beneficial - No benefit)
The workshop was:	4.63	(Well organized - Disorganized)
My general impression of the workshop was:	4.71	(Excellent - Poor)
This workshop met my needs:	4.46	(Very well - Not at all)

Attachment B contains a summary of a follow-up written questionnaire, mailed to participants at 7 replication sites. There were 19 respondents, from 5 sites. This follow-up was done anonymously, as several participants expressed concern to project staff about being able to express themselves freely at the focus groups where local leadership/coordinators were also participating. Project instructors concurred that this form of evaluation feedback might also encourage candid responses from those who had participated in the training. Comparison of the responses to the questions in the focus group (Attachment A) indicates that there was considerable similarity expressed in the two evaluation methods. Both focus groups and follow-up questionnaires indicated participants' satisfaction and included suggestions for improvement.

To what extent do participants view the training as useful and relevant?

Responses to a structured format in question 2 (shown in Attachment B) directly address this evaluation question. All 19 respondents indicated that they had used the DTORF-R for assessment, and all but 1 also indicated use of the DTORF-R in program planning. In addition, 79% used the DTORF-R for pre-post- evaluation and for selecting developmentally appropriate materials; while over half reported using the DTORF-R for grouping children (52%). Their anecdotal responses reflected this same informal ranking of the elements in the training that were most helpful to them.

Do the participants perceive the training as positive and constructive for themselves and the children they work with?

Responses to question 3, (Attachment A) verify the conclusion that **all of the participants viewed the training as positive, useful, and relevant** -- all of the responses to this question were positive. They indicated that the training affected their thinking about children and their own ways of working with them. Specific examples supported the conclusion that the basic content elements of the model were included in the training and are perceived by the participants to be useful and relevant.

Questions 4, 5, and 6 provided the participants with the opportunity to evaluate (address) the training as it applied to their specific programs, staff, and time constraints.

Further, these questions enabled respondents to make suggestions that related to personal needs and wants for maximum successful utilization of the model. The responses to these questions indicate that additional training and more follow-up with direct observations and feedback would be beneficial.

What suggestions do participants make for changes in the design and implementation of future training with this model?

The respondents made many useful suggestions for increasing the usability of the model. These ideas are summarized in question 7 (Attachment A) and in question 7 (Attachment B). Essentially all of their ideas reflected a need for additional training with multi-media, real- life illustrations, and practical applications demonstrated through video and case materials. These recommendations are now under consideration and implementation in future planning as explained in the following section.

IX. PRODUCT DEVELOPMENT AND LONG RANGE IMPACT

This inservice training project focused to a considerable extent on a group of early childhood personnel which is frequently overlooked - the paraprofessional or untrained care giver - working in inclusive early childhood settings alongside professionally trained early childhood educators. They often carry a large share of responsibility for the success of inclusive programs of young children with disabilities as well as for those at risk.

Because the original Developmental Therapy - Teaching model was validated for its effectiveness when used by teams of professionally trained teachers, the present project required several model adaptations, including: (1) greater focus on "talking through" in the training procedures for reliable use of the child-assessment instruments; (2) discontinuation of the use of paper-pencil tests to evaluate participants' knowledge; (3) use of volunteer focus groups regarding developmental practices for evaluative project effectiveness feedback; and (4) preparation of training modules which provide participants direct with more practice and applications of specified procedures and activities.

This latter need was so great among participants that a compilation of activities was undertaken during the grant period. It is now in draft form and should be available for use in the field within the year. In addition, a list of several commercially available activity books has been prepared by the staff to aid users of the Developmental Therapy - Teaching model with ideas for activities to address specific developmental objectives. These developmentally-referenced activities should have a wide market in the early childhood field because of applicability for children with and without disabilities in inclusive settings. A commercial publisher will be sought. Several in-house audio-visual training materials were also revised during the grant periods, to update visuals and adapt scripts to the expanded training audiences. These include (1) A color slide-audio presentation of the steps in using the DTORF-R to assess a child's current status in social-emotional-behavioral development; (2) a video cassette illustrating the unique social-emotional-behavioral characteristics of children at each stage of development; and (3) how adults adjust their own management styles to the developmental characteristics and needs of children with social-emotional-behavioral lags. These in-house training materials will be available to leadership people trained and certified as instructors by the Developmental Therapy Institute.

X. STATEMENT OF FUTURE ACTIVITIES

It is anticipated that several of the present replication sites will designate an on-site individual as a leadership person in the next school year. The need to have such a person locally was expressed repeatedly by participants in the present project. Participants particularly expressed the need to have such a person available to (1) give direct feedback from observations about difficult-to-manage children; (2) provide ideas for ways to enhance children's program activities; (3) assist in inservice for new staff members (staff turn over and re-assignments are a huge problem at the local level); and (4) assist in educating staff of inclusive programs to the applications of the model for participating children with disabilities.

Several individuals and programs have initiated discussions with project staff to continue their own leadership training in response to this need. Through the Developmental Therapy - Teaching Programs at the University of Georgia, these potential leadership people will be provided with advanced training and certification as instructors. This network of individuals is expanding and it is anticipated that each will be able to generate second generation quality replications. The network will maintain connections and consultation with them through the Institute's Web pages on the Internet, long-distance learning via satellite, newsletters, regional conferences, and via new commercial and professional publications.

XI. ASSURANCE STATEMENTS

A copy of this full final report has been sent to ERIC and copies of the title page and abstract/executive summary have been sent to the other designated addressees.

♦♦♦♦♦♦♦

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION PROGRAMS

Final Performance Report
SOCIAL COMPETENCE FOR YOUNG CHILDREN:
AN OUTREACH PROJECT FOR INSERVICE TRAINING (84.024D)
(Multi-State Outreach Project)

Part I

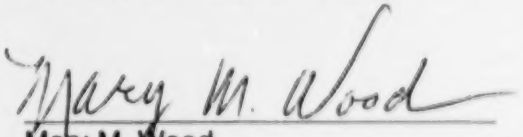
1. Date of Report: August 1, 1997 2. Grant Number: H024P30068-95

3. Period of Report: From October 1, 1993 to September 30, 1996 (extended to February 28, 1997)

4. Grantee name and Descriptive Name of Project:

   University of Georgia: College of Family and Consumer Sciences
   Social Competence for Young Children: An Outreach Project for Inservice Training

5. Certification. I certify that to the best of my knowledge and belief this report is correct and complete except as may be specifically noted herein.



Mary M. Wood
Interim Project Director
Developmental Therapy-Teaching Programs
College Square Building
191 East Broad Street
Suite 309
Athens, Georgia 30601-2801

ATTACHMENTS

Attachment A: Summary of Follow-up Questionnaire: 7 Sites

Attachment B: Summary of Focus Group Responses: Sites 1 & 2

Attachment A
Summary of Focus Group Responses: Sites 1 & 2
n = 20 Participants

(Responses to each question are summarized with most frequent responses first)

1. ***What is the extent of your training opportunities with this project?***
   - 2 days of workshops - (12 hours by project instructors)
   - 3 days of workshops - (18 hours by project instructors)
   - 20 hours (by project instructors)
   - Seminars (by a project leadership participant)
   - Parallel college course (by a project leadership participant)
   - Study of project packet of materials
   - Observation of child assessment procedure

2. ***Describe your use of aspects of the training.***
   - Use of the assessment procedure
   - Recognizing developmental milestones in children's behavior
   - Planning for developmental milestones on curriculum activities
   - Understanding why certain strategies should be used
   - Understanding why children do what they do (decoding behavior)
   - More feeling for what child is feeling
   - How to manage problems with effective, positive strategies: e.g.
     Using proximity/modeling/eye-level contact/body language/adult interaction (lead & support roles)
     Affirming children's behavior/affirming their feelings
   - Making positive instead of negative statements
   - Structuring choices for children
   - Using "easy, supportive touch"
   - "like a painting of their developmental mind grade"

3. ***How could this model be used fully in your own setting?***
   - Assessing all children (those without disabilities) to design individual objectives & program
   - Increasing amount & frequency of parent-teacher staffings
   - Planning curriculum
   - Meeting individual children's needs
   - Integrating our children with special needs into regular classrooms
   - Grouping breakout groups for specific needs and objectives
   - Expanding parents' understanding of children's needs at home & school
   - Expanding parents' understanding of children's program objectives
   - Orienting to individual needs and objectives rather than by labels
   - Recognizing individual rates of development
   - Recognizing administrative support for teachers in the program

- Providing more follow-through in inclusive setting with regular staff
- Using the color-coded bar graph of a child's progress
- Providing more staff time for assessing more children
- Providing someone else to do the paper work
- Changing mind sets about discipline & power struggles between some teachers & children

4. ***How has the model/project affected your thinking about how you work with children -- or your actual work?***
   - Understanding of children's patterns, rates, & sequences of development
   - Ways to put developmental concepts into the program & curriculum
   - Ways to group in classes
   - Helps to guide children's progress developmentally
   - Support & supervision of classroom personnel (from leadership participant)
   - Understanding goal setting & individual program variation (from leadership participant)
   - Making strategic decisions for individual program direction

5. ***Describe things which may have limited your use of the model, or been a constraint.***
   - Children's repeated assessment schedule was too limited (Assessments need to be more frequent for better understanding of a child)
   - Time limitations for child assessments and individual team planning, especially with parents
   - Monitor actual gains more closely so that corresponding program changes can be made
   - Local & state program policies (requirements for age groupings and staff ratios) are not sufficiently flexible for program needs of individual children
   - The assessment questions (DTORF-R) are too hard
   - They (DTORF-R) need to be written so people can understand them without reading "every little bit of it"
   - "The list of kids that need to be assessed is too long"
   - "It tells you what to do and what not to do"
   - Its hard to stay on the planned assessment schedule
   - Its difficult to involve parents and staff in the other (regular) classrooms

6. ***What needs do you still have about the use of the model, which could be constraints also?***
   - *More time is needed for child assessments and team planning*
   - *A collection of suggestions/activities for meeting individual objectives (in the group)*
   - More resource materials to address individual & group objectives
   - More feedback is needed about reliability in using the model
   - A print-out of each developmental profile/rating for parents

- A guide for parents to use similar, positive management strategies
- We have too many kids for recommended size of groups
- Time is needed for teachers to have individual breaks
- One staff person is needed to go from room-to-room for feedback and resource-ideas

7. ***How can we make the training experience more helpful?***
   - Provide a resource book of activities to meet specific objectives
   - We need a way to share ideas & activities
   - Video examples of management strategies would be helpful
   - Use video for illustrating the steps in rating with the DTORF-R
   - The inservice training needs to be longer (e.g., 7 weeks)
   - Space out the training and focus in more detail
   - Include homework and planning actual classroom activities
   - Provide a CD ROM with suggestions about ways to work on the objectives
   - Give detail on ways to work on the same objective with children of different ages
   - Use a famous movie like "Tom Sawyer" to practice DTORF-R ratings
   - Have everyone practice DTORF-R ratings on the same child and then follow up with discussions

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Attachment B.
Summary of Follow-up Questionnaire: 7 Sites
19 respondents

(Responses to each question are summarized with most frequent responses first)

1. ***What is the extent of your training opportunities with this project?***
(13 responses)
   - 1 day workshop - (4-6 hours by project instructors)
   - 2 days of workshop - (12 hours by project instructors)
   - 3 days of workshop - (18 hours by project instructors)
   - Observation of child assessment procedure
   - 3-5 seminars (by project instructors)
   - 20 hours (by project instructors)
   - Seminar (by a project leadership participant)
   - Parallel college course (by a project leadership participant)
   - Study of project packet of materials
   - Observation of child assessment procedure
   - Observation/visit by staff to classroom

2. ***Which components of the model have you used?***
   - DTORF-R assessment procedure (15 responses)
   - DTORF-R results for program planning (14 responses)
   - Selecting developmental appropriate materials (13 responses)
   - DTORF-R results for grouping children (11 responses)
   - Planning developmentally schedules (10 responses)
   - Understanding team roles (10 responses)
   - DTORF-R pre- post- evaluation (9 responses)
   - Understanding why children do what they do (decoding behavior) (8 responses)
   - Using positive management strategies (6 responses)

   Which ones have you found most helpful?
   - The DTORF-R for assessment and understanding developmental differences (9 responses)
   - Developmentally appropriate schedules, material, & activities (6 responses)
   - Individual program planning (5 responses)
   - Team work and team roles (4 responses)
   - Grouping children for program planning (3 responses)
   - Decoding behavior/understanding/empathy (3 responses)
   - Positive management strategies (2 responses)

3. ***Has Developmental Therapy-Developmental Teaching affected your thinking or beliefs about working with children?***
(All 15 answered in the positive)

In what ways?

- Meeting individual children's needs
- Designing individual programs
- Planning curriculum
- Recognizing individual rates of development
- Understanding of children's patterns, rates, & sequences of development
- Way to group children
- Ways to provide developmentally appropriate structure
- Understanding different needs individual children have
- Additional techniques for working with children
- Using reflection and other positive strategies to build bond/relationships with children

Affected your actual work with children?

(All 14 were positive responses, with 8 "yes")

- Understanding different needs of individual children/different goals
- Using different strategies to meet different individual needs
- Assessing children and using the scoring to plan programs; different strategies to meet different individual needs

4. ***Describe any things which may have limited your use of the model.***

(14 responses)

- A lot of information in 2 to 3 days
- Assessing children who are in our program less than 6 months
- Time limitations for doing child assessments as frequently as desirable
- Providing more staff time for assessing children
- Providing more staff time for planning
- Staff turnover, with time between training too long to get new staff up to speed
- Frequent reviews would help recalling best practices to use
- More training needed
- More time needed to implement exemplary practices
- DTORF-R is not written in easy-to-understand language

5. ***Explain any needs you may still have about using the model?***

(13 responses)

- Suggestions of activities for meeting individual objectives (in the group)
- More training
- Annual refresher course
- More information about DTORF-R group ratings, overtime, and calculating percentages
- Additional follow-up in the classroom by project instructors
- no additional needs
- Immediate training for new staff members
- Real life examples of healthy intervention strategies

6. ***How can we make the training experience more helpful?***
(16 responses)
- Provide more observing and feedback
- More training on the DTORF-R
- Information about when refresher training will be offered
- Additional focus on implementing in the classroom
- More training in specific activities to meet objectives
- A training video
- Train an experienced teacher (on site) to teach new staff
- Role play how to use (methods)
- Emphasize that parents do not have to be present (to do the assessment)
- Use specific cases to illustrate applications & examples

7. ***How can we increase the usability of the model?***
(14 responses)
- Provide books & videos to use as reference at local site
- Provide a trainer to assist in assessments, problem-solve & general implementation at local site
- Give more detail on ways to work on the same objective with children of different ages
- Provide a computer disk to input information
- Video conferences to train new staff & update others
- Model is very usable!
- Provide specific suggestions and in-depth on tactics to meet specific objectives
- Demonstrate with real life situations or examples

8. ***Are you more likely to include children with social-emotional-behavioral delays in your program following training?***
(16 responses)
- 10 responses that they already have a considerable number of children with such disabilities
- 6 "yes" responses